MARYLAND

Perinatal network

Robert L. Ehrlich, Jr., *Governor*
Michael S. Steele, *Lt. Governor*
S. Anthony McCann, *Secretary*

Electronic Newsletter

Early Winter 2005

Maryland Department of Health and Mental Hygiene

The Perinatal Network News is a publication of the Department of Health and Mental Hygiene's (DHMH) Center for Maternal and Child Health (CMCH). It is funded through a Crenshaw Perinatal Health Initiative grant provided to the Montgomery County Health Department.

The publication is intended as a communication tool for sharing perinatal information for a statewide audience, with information and resources that address statewide issues. It is designed as a vehicle to encourage collaboration and networking throughout the state. The newsletter provides an opportunity to share information on preconception and perinatal health issues and priorities, infant morbidity and mortality, county statistical trends and perinatal and child health indicators. It is an opportunity for local programs to share their strengths and insights as well as an opportunity to ask for feedback and assistance in solving a local problem.

To ensure that this newsletter is a success, we need and encourage your participation. Please let us know of any items you would like to contribute, or if you have suggestions for topics or areas you would like to see covered.

Contact Andy Hannon at 410-767-6716 or e-mail at *hannona@dhmh.state.md.us*. Fax: 410-333-5233.

Introducing the NEW and Expanded Perinatal Network News

Hello Perinatal Colleagues,

I want to take the opportunity to introduce the Perinatal Network newsletter – the State of Maryland's newest project to enhance communications and networking for the Maternal/Child Health community.

The Perinatal Network newsletter, a quarterly publication has, since 1999, been published by Montgomery County, funded under a Crenshaw Grant. It has been received with enthusiasm from its readers who have included County OB/GYNs, pediatricians, school heath personnel, hospital staff, clinic and health workers and many at Montgomery County Health and Human Services. The newsletter has covered medical issues such as post-partum depression, STDs, teen pregnancy, and pre-eclampsia among others. It has also served as a vehicle for state and county perinatal and administrative information.

Beginning with this fall issue, the newsletter is going statewide and will be published in electronic format as a pdf file. The newsletter is very much a community-minded, grass roots publication for the perinatal community. Many of the articles and news information published comes directly from personnel in the field. We intend to continue this strategy and will be encouraging participation from all corners of the state

We are currently working to put together the e-mail mailing list and hope to reach a wide target audience. The editor, Jody Joy, will be sending out an e-mail prior to the publication of each issue requesting submissions of articles, news and information. From simple two or three paragraph descriptions of projects and department undertakings to one-page articles on timely topics, all your contributions will be welcomed.

The newsletter is intended to serve you the professional perinatal community. We look forward to giving you the opportunity to let your colleagues hear about and share in your work. The Perinatal Network newsletter is meant to serve as a resource for state and county perinatal professionals and with your assistance should be an informative and enjoyable publication.

Maureen Edwards, MD

Medical Director, Center for Maternal and Child Health, DHMH

Chronic Disease and Pregnancy

Maureen Edwards, M.D., M.P.H., Center for Maternal and Child Health, DHMH

Many women with a chronic disease have successful pregnancy outcomes. However, the importance of preconception counseling for women with a chronic disease cannot be overstated. Women with high blood pressure, HIV disease, diabetes, asthma or other chronic health conditions benefit greatly from consultation with their health care provider before getting pregnant.

Some chronic health conditions can worsen during pregnancy or increase the risk of complications for the mother and/or child. For example, a woman with high blood pressure, before she becomes pregnant, has an increased risk for developing pre-eclampsia during pregnancy. Poor management of diabetes mellitus (Type 1 and Type 2) increases the risk of congenital anomalies and uncontrolled asthma can lead to prematurity and low birth weight.

Additionally, some medications taken for chronic health conditions can negatively impact a pregnancy. Consultation with a health provider prior to conception is very important for determining the appropriate medication for managing a chronic disease during pregnancy.

Preconception counseling can reduce the risk to mother and child under all of these circumstances and more by determining the proper management of the chronic health condition through appropriate medication, diet or other course of treatment. All women, with or without a chronic health condition, should strive to be their healthiest before pregnancy for the child's benefit as well as their own.

❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖

Maryland Perinatal Association is Active Once Again

Efforts are actively underway to revitalize the Maryland Perinatal Association (MPA). The MPA, a non-profit, multi-disciplinary organization comprises maternal and child health professionals of all types and is seeking new members interested in networking, educational sessions, and advocacy efforts to improve the health of mothers, babies and families across the state.

Specifically, we are looking for individuals who are interested in being very active members of a board of advisors, information on hot topics that we need to advocate for, as well as suggestions for topics for educational sessions we plan on convening between now and June 2005.

If you are interested in learning more about the MPA and/or would like to become a member, please contact Gillian Silver at *gsilver@jhsph.edu*.

Calling Perinatal Colleagues!

Frederick County Health Department Maternal Child Health—Improved Pregnancy Outcomes Program

Burneda M. Russell, RN BSN, Coordinator Improved Pregnancy Outcomes Program, FCHD; National SAFE KIDS Campaign; State of Maryland Center for Preventive Health Services

In FY04, two patient education pamphlets were developed by Frederick County's Improved Pregnancy Outcomes Program and the SIDS Risk Reduction Campaign. During FY 98-03, 18 percent of the cases reviewed identified problems/needs related to prenatal care. One of the major issues revealed was the lack of maternal knowledge about preterm labor, fetal movement, and the associated pregnancy complications. The FIMR Case Review Team (CRT) made the recommendation to develop a fetal movement count pamphlet and make it available to our community in both English and Spanish. This was achieved through a March of Dimes Community Grant. Our local obstetrical providers distribute the pamphlet. This initiative was presented at the Fifth National Fetal and Infant Mortality Review Conference's Poster Session in Washington, DC on August 13, 2004.

Reducing the risk of SIDS in our community has been an outreach initiative since 2000. A new partnership with FCHD's Injury Prevention Program and SAFEKIDS has enabled the message "BACK TO SLEEP TUMMY TO PLAY" to reach high-risk families through a home safety program.

Prevention is the CURE

Unintentional injury remains the number one killer of children age 14 and under. It is estimated that by taking simple precautions, almost all (90 percent) of these unintentional injuries can be avoided. Taking simple prevention measures and closely supervising children can help protect them from common household hazards, such as fires, burns, drowning, suffocation, choking, firearm injury, poisoning and falls.

Frederick County Health Department's Injury Prevention Grant, Improved Pregnancy Outcomes and Healthy Start Home Visiting Programs are working together with SAFE KIDS Frederick County to prevent unintentional injuries to infants' age zero to one year and have developed a Home Safety Kit.

Home Safety Kits

Community Health Nurses are distributing the SAFE KIDS Home Safety Kits to families with infants and young children who participate in the Healthy Start Home Visiting Program. Parents are taught about the prevention of common childhood injuries and are given a kit filled with age appropriate safety information and safety devices. In addition, emphasis is given to SIDS risk reduction behaviors and firearm safety. The Sheriff's office provided a firearm safety demonstration and in-service training for the nurses. Promoting firearm safety and teaching parents safe storage of firearms is an important part of helping parents provide a safe environment for their children and family. Firearm safety locks are provided by the Sheriff's office and the Frederick Police Department. The nurses will offer the cable-style gun locks to families with infants and young children during their Healthy Start home visits.

New Web Site Integrates Detailed Perinatal Health Data

A new PeriStats database and Web interface were implemented recently to integrate access to detailed city and county data on maternal and infant health in the United States. Complete and in-depth county coverage is still under development. The new Web site represents the first milestone of a partnership between the March of Dimes Perinatal Data Center, the National Library of Medicine, and the New York Academy of Medicine to increase access to city, county, state, and national perinatal data and to improve the utility of PeriStats. More than 50,000 graphs, maps, and tables have been added to the PeriStats system to date. Future efforts will include integrating access to relevant biomedical literature. The Web site is intended to be used for fact-finding, regional health assessments, grant writing, policy development, lectures, and presentations.

An overview of the new features is available at *www.marchofdimes.com/peristats/whatsnew.aspx?id=6.*

The PeriStats Web site is available at *www.marchofdimes.com/peristats.*

Sharing Successes: Statewide Annual FIMR Meeting

Christy Woods, MedChi, The Maryland State Medical Society

The Center for Maternal and Child Health, Maryland DHMH, held its Annual Fetal Infant Mortality Review meeting on October 22. More than 50 attendees, representing local FIMR Programs throughout the state, convened at Historic Savage Mill. The Breakout/Roundtable Sessions and presentations provided opportunities for networking, sharing best practices, and planning on a local level. Presentations covered a range of topics at the state level, as well as the impact local FIMR programs have had in improving services to women and families.

Topics included: changes to the 2005 Fetal Death Certificate, approaches to examining Perinatal Disparities, key PRAMS findings, prevention of perinatal infections, maternal health infrastructure, peer to peer breast-feeding support group, perinatal bereavement, how autopsy results impact local FIMR efforts, the Women's Wellness Center in Prince George's County and partial patient-funded prenatal care programs in Anne Arundel County and on the Lower Shore.

Maryland FIMR Technical Assistance

MedChi will continue to provide technical assistance to the local FIMR programs. The Maryland FIMR Advisory Group will be instrumental in working on several key areas: coordinating FIMR with other perinatal efforts; developing tools and database; communicating FIMR successes and issues; and identifying resources to support FIMR activities. FIMR Coordinators are encouraged to provide feedback on proposed activities. Meeting dates will be forwarded via e-mail to the Local FIMR Coordinators.

The Perinatal Newsletter will dedicate one page per issue for FIMR programs to highlight activities. Please share the great things going on in your community that might inspire others in their efforts.

For further information or to share ideas, please contact Meena Abraham at *mabraham@medchi.org* or 410-539-0872 x322 or Christy Woods at *cwoods@medchi.org* or 410-539-0872 x357.

Birth Defect Blood Test Might Also Predict Risk of SIDS

Blood tests that are performed during pregnancy to determine if a fetus is at risk of birth defects might also help predict if an infant will be at an increased risk for sudden infant death syndrome. SIDS, also known as crib death or cot death, is a leading cause of infant death in developed countries.

Alpha-fetoprotein (AFP) levels in the blood of pregnant women indicate how well the placenta is functioning and are often measured to determine if a fetus will be born with birth defects, according to Dr. Gordon Smith, the study's lead researcher and a professor of obstetrics and gynecology at the University of Cambridge in the United Kingdom. High AFP levels are a sign that the placenta is not working optimally.

Smith and colleagues analyzed data from AFP tests performed between 1991 and 2001 in Scotland on women in their second trimester of pregnancy. Of the total 214,532 live births, 114 SIDS deaths were recorded, resulting in a rate of 5.3 SIDS deaths per 10,000 live births. The researchers found that women with the highest levels of AFP were twice as likely to have an infant die from SIDS than women with the lowest levels.

"This is significant research," Smith said, adding, "But it is not significant because we will be able to offer women a diagnostic test, it is significant because it helps us understand the causes of cot death. It also shows conditions in pregnancy are a major determinant of the vulnerability of the baby to cot death." Smith added that the risk of SIDS was still "relatively low." The women in the study with the highest levels of AFP had infants with a one in 1,000 chance of SIDS, compared with an average risk of one in 2,000.

Announcing the First Edition of the "NICHD Community Connection Newsletter— "Advancing the Health of Families in Your Community"

The focus of this issue is SIDS and Infant Mortality. The publication is now available online at: *www.nichd.nih.gov/publications/pubs/NICHD_com_connect_june04.pdf.*

Unraveling the Mystery—You Can Help!

Carol W. Garvey, MD, MPH, Garvey Associates, Montgomery County

The Women's Health Program in Montgomery County and other jurisdictions would like to deputize all physicians—especially those in obstetrics. We need your help in solving the mystery of many of the fetal and infant deaths in the county.

For six years, the Montgomery County's Fetal and Infant Mortality Review (FIMR) Board and its Community Action Team (CAT) have been studying fetal and infant deaths, with a view toward identifying preventable contributing factors. Similar efforts are taking place in other Maryland counties.

While we expect that hospital quality assurance committees look at the specific medical issues surrounding fetal and infant losses, our reviews take a much broader look at the context of a pregnancy. Was the mother in poor health prior to conception? Did her employment put undue physical stress on her during the pregnancy? Were there social factors which affected her health and sense of well-being? Were there congenital anomalies or other abnormalities in the infant which could affect the success of future pregnancies?

Our reviews start at the hospitals, where a registered nurse reviews charts of women who have experienced fetal or infant loss. Efforts are made to contact many of these women for detailed interviews which address the issues above, and many others. Findings are then shared with the FIMR Board, which consists of a spectrum of professionals (obstetricians, neonatologists, nurse midwives and nurses, social workers, addiction counselors, etc.).

The patients, physicians, and hospitals remain completely anonymous. Our concern is not so much with the specific case as with its implications for improving pregnancy outcomes for other women. Cases in which there is pending litigation are not reviewed by the FIMR Board. In order for us to acquire as much useful information as possible, your help is particularly important in two areas.

We need clearer records. Poor handwriting complicates the efforts of the reviewing nurse to obtain the details of the course of a woman's pregnancy. Incomplete prenatal records are another problem. We are extremely grateful when we find a prenatal record which is complete and legible. If requested by a nurse reviewer, we would appreciate your office sharing the records of a mother who has delivered prematurely before a copy of the prenatal record is delivered to the hospital.

We need autopsies. All too often, the actual reasons for fetal or infant demise are not determinable from the clinical course of mother or baby. Many parents lack understanding of the benefits of an infant autopsy, and many physicians are reluctant to pursue autopsies with bereaved parents. We urge you to try to overcome parental resistance by pointing out that the information gained may be very helpful in the planning of future pregnancies and may also help clear up any misconceptions a parent may have about the conduct of the prenatal care. In many of our interviews, women have claimed that a loss would not have occurred, had a health care provider attended to a particular maternal concern, when, in fact, it is clear that care was appropriate and that the loss was probably inevitable. When bereaved parents lack understanding of the cause of a loss, their approach to future pregnancies may be impaired and may result in further losses.

With your help, we may do a better job of understanding why women who are educated and insured and who enter care early in their pregnancies may still experience poor pregnancy outcomes—particularly if they are African American. We may then try to mitigate the factors which contribute to these poor outcomes.

We can help with your patients. As part of the effort to prevent poor pregnancy outcomes, county health departments and their private partners have a number of programs in place to help pregnant women successfully address the non-medical problems which might contribute to negative consequences for the pregnancy. In Montgomery County, these include:

* Healthy Start, a national program with offices in every county for low-income pregnant or postpartum women who have children under two years of age at risk for poor health outcomes, non-compliant clients, or families with special needs children (In Montgomery County, call 240-777-3380). In most counties, the program is open both to uninsured women and to women receiving medical assistance.

* The Black Babies SMILE program-a nurse-based case management system designed to complement the clinical care received by high-risk black women and newborns, managed by Montgomery County's African American Health Program (call 240-777-4471). This service is available to all African American women in Montgomery County, regardless of income.

* ChildLink, an informational and resource system to connect families to services which address problems of children from conception to five years of age in Montgomery County (contact 240-777-4769). This program can link pregnant women and new mothers with a variety of programs for those at high risk, such as Healthy Families, Early Head Start, and services for children born with disabilities.

You are encouraged to call your local health department for assistance with your high risk patients. Their staff can help address some of the non-medical issues which may endanger a pregnancy and can help pregnant women to follow the recommendations of their physicians.

Excellent medical care during pregnancy is essential but not sufficient. Through the FIMR Board, and its associated Community Action Team, we plan to continue our efforts to identify and reduce or eliminate factors of all kinds which result in poor outcomes. We need your participation if we are to be successful in this endeavor.

Smoking Cessation Interventions for Pregnant Women

Karen Udwari, RN, Perinatal Coordinator, Montgomery County

The Montgomery County Fetal and Infant Mortality Review (FIMR) board members have identified the need to eliminate smoking during pregnancy, which is in alignment with the Healthy People 2010 goals. These goals are a set of health objectives for the Nation to achieve over the first decade of the new century. According to the National Vital Statistics Reports in 2000, 12 to 20 percent of all pregnant women smoke. Smoking while pregnant can result in adverse outcomes such as placental abruption and separation, low birthweight, and increased perinatal mortality. Women who smoke are more likely to have babies that die from Sudden Infant Death Syndrome than their non-smoking counterparts.

The American College of Obstetricians and Gynecologists(ACOG) provides "A Self-Instructional Manual for Obstetric Providers: Helping Pregnant Smokers Quit." This manual can be obtained free by calling ACOG at 202- 484-3917. In addition, Public Health Service Guidelines for clinicians are available for free online at *www.surgeongeneral.gov/tobacco/tobaqrg.htm*.

According to the U.S. Department of Health and Human Service guidelines, clinicians should offer smoking cessation interventions at the first prenatal visit and throughout the pregnancy.

Complete avoidance of all nicotine should be the primary objective during pregnancy and beyond. However, women who continue to smoke while pregnant are likely to be highly addicted and may require more than counseling and behavioral support. These women may benefit from nicotine replacement therapy (NRT) in addition to counseling and behavioral support. It is important to note that NRT is not the ideal choice for pregnant women. Published data establishing the effectiveness and safety of NRT are lacking, and NRT is only recommended in extreme cases. For the pregnant smoker who is unable to quit using non-pharmacological therapies, NRT will assist by delivering less nicotine with none of the other potentially disease-causing agents. According to the *British Medical Journal* article entitled, "Nicotine replacement therapy in pregnancy" April 2004, "Any harm caused by nicotine replacement must be compared with that caused by continued smoking-which is extremely harmful to both the mother and her child."

As clinicians work to improve birth outcomes, the use of nicotine replacement therapy for pregnant smokers otherwise unable to quit, has the potential to improve perinatal health for both mothers and children.

Report on Progess in Meeting Healthy People 2010 Goals for Smoking During Pregnancy

Since 1990, maternal smoking for females aged 15-19 years has fluctuated. The Healthy People 2010 objectives target an increase in smoking cessation among pregnant smokers during the first trimester to 30 percent and abstinence from cigarettes to 99 percent of all pregnant women. The report summarizes analyses to assess progress toward meeting these health objectives.

Two years of available data on smoking during pregnancy among adolescents ages 15-19 were averaged and compared for three periods: 1990-1991, 1995-1996, and 2001-2002.

The authors found that:

- During the study period, smoking during pregnancy decreased by 38 percent among all women giving birth in the United States (from 18.4 percent in 1990 to 11.4 percent in 2002).
- All states and jurisdictions with comparable data reported significant declines in smoking during pregnancy; however, declines were variable, from 5.8 percent in West Virginia to 68.0 percent in Massachusetts.
- Every year from 1996-2001, a higher percentage of adolescents ages 15-19 smoked during pregnancy than women in any other age group. In 2002, the percentage of adolescents ages 15-19 who smoked during pregnancy was the same as that for women ages 20-24, with the highest among adolescents ages 18-19.
- Of the 45 states and jurisdictions in which the percentages of women who smoked during pregnancy could be calculated for adolescents ages 15-19 for both 1995-1996 and 2001-2002, 10 had a complete trend reversal (i.e., from a significant decrease between 1990-1991 and 1995-1996 to a significant increase between 1995-1996 and 2001-2002).
- Thirteen states had consistent and significant declines in smoking among pregnant adolescents ages 15-19, both from 1990-1991 to 1995-1996 and from 1995-1996 to 2001-2002; however, four states had significantly higher percentages in 2001-2002 compared with 1990-1991.

Mathews TJ, Rivera CC. 2004. Smoking during pregnancy, United States, 1990-2002. Morbidity and Mortality Weekly Report 53(39):911-915; available at *www.cdc.gov/mmwr/preview/mmwrhtml/mm5339a1.htm*.

Perinatal Smoking Cessation—Babies Against Second Hand Smoke (B.A.S.S.)

Loretta Welborn, RN, Maternal/Child Health Nurse, Calvert County

Perinatal smoking in Calvert County is above the Maryland State average. In 2001, the rate of tobacco use was 32.1 percent for the Medical Assistance population in Calvert County compared with 25 percent for Maryland. In an effort to reduce the use of tobacco among pregnant women, the Calvert County Health Department has developed a program called B.A.S.S., Babies Against Second Hand Smoke. Collaboration with the local obstetrics and pediatric providers will enhance this effort.

Educational packets are being developed to distribute to OB providers that include the harmful effects of smoking on the fetus, self-help materials, environmental dangers of second hand smoke, a resource list of all the Calvert County smoking cessation programs, and the one-on-one counseling available at the Calvert County Health Department.

The effects of smoking during pregnancy are severe. Low birth weight, high rates of SIDS, behavior problems and learning difficulties are just part of the negative impact of smoking. Some studies have shown an elevated risk of cancer in children of smokers. Smoking can reduce the amount of oxygen and blood flow the fetus receives thereby affecting the heart rate, oxygen supply and blood pressure of the fetus. Approximately 4,000 babies would be saved each year if all pregnant women quit smoking.

A smokers screening tool was developed and is now a part of the Healthy Start assessment. When a pregnant woman completes the one page risk screen, and indicates an interest in quitting, she is contacted by the staff. Educational material and information along with counseling is provided to help her through this effort. A bib with the program logo is given to the client for her baby.

During pregnancy women are very motivated to quit smoking, mostly for the welfare of the baby and then for themselves. Most women, an estimated 80-85 percent, are able to stop smoking during pregnancy, but almost 60 percent return to smoking after the baby is born.

The health department will keep in contact with the client after the birth of the baby to help her remain smoke free and protect the infant from the dangers of second hand smoke.

Collaboration & Counseling

Smoking Trends Before, During and After Pregnancy

The odds that a woman quit smoking during pregnancy increased 51 percent between 1993 and 1999. In contrast, the odds of smoking three months before pregnancy were unchanged over this period, while postpartum relapse rates have tended to rise. The study evaluated trends in smoking before, during, and after pregnancy in 10 states, attempting to fill a gap in population-based data on prenatal quit and postpartum relapse rates.

The authors used survey data from 10 states that participated in the Pregnancy Risk Assessment Monitoring System (PRAMS) for at least five of the seven years between 1993 and 1999. The authors used the detailed survey information to describe the correlates of smoking before pregnancy, as well as the correlates of smoking quit and relapse rates among pregnant women and recent mothers.

The authors found that:

▼ By 1999, the odds that a woman would quit smoking during pregnancy were 51 percent greater than in 1993.

▼ Over 40 percent of women quit smoking from the period three months before pregnancy to three months before delivery, but almost 60 percent resumed smoking within six months postpartum.

▼ Primiparous, college-educated, privately insured women were less likely to smoke prior to pregnancy, more likely to quit during pregnancy if they smoked prior to pregnancy, and less likely to resume smoking after pregnancy (if they had quit) than multiparous, less-educated, Medicaid-insured women.

Although teenagers were more likely to quit smoking during pregnancy than were older women, teenagers were also more likely to resume smoking after pregnancy.

The authors state that increased quit rates appear not to have reduced postpartum smoking. Targeting antismoking therapies at women who have quit during pregnancy may be an effective way to reduce the danger to infants and older children from second-hand smoke.

Coleman GJ, Joyce T. 2002. Trends in smoking before, during, and after pregnancy in ten states. American Journal of Preventive Medicine 24(1):29-35.

Nutrition in the First Year of Life

Amina Watson-Miller, MD, F.A.A.P., private practice, Montgomery County

It is important to establish healthy eating habits for your child from the very beginning. Pregnant moms should have a balanced diet, take a prenatal vitamin daily, drink plenty of fluids, and get regular exercise.

In the first few months of life, babies should only take breast milk or formula. There are many advantages to breast feeding. Breast milk is especially designed for baby, and naturally contains DHA and ARA, which are the brain building nutrients now being added to formulas. Breast feeding may also reduce the potential for obesity in your child. Breast-fed babies naturally will stop eating when they are satisfied, whereas parents may sometimes encourage formula fed babies to finish a full bottle. Learning to regulate their appetite this early helps baby's brain develop this good habit of self-regulation. Babies should always be fed on demand, but it is also important to learn to recognize when baby is satisfied. Breast feeding is also inexpensive. The average cost of formula is anywhere from $30 to $60 a week or more. The greatest expense most breast feeding families will face is the cost of a pump, if mom is pumping. Breast pumps range from thirty dollars to $250, but this is a one time expense.

There are several types of formulas available. Most of them now contain DHA and ARA, which are naturally found in breast milk. Some formulas are made with cow proteins, and some are made with soy protein. Most babies tolerate the cow protein based formulas well, but for those who have a strong family history of lactose intolerance, or have a lot of gastrointestinal upset with a cow protein based formula, a soy protein formula or an even more simplified formula with broken down proteins may be right for baby.

For the first four months of life, babies should only receive breast milk or formula. No other foods or liquids are needed. In fact, introducing foods too early to baby can cause food intolerances or allergies because newborn babies' gastrointestinal tract is not mature enough to handle anything other than human milk or formula. Sterilized water can be given occasionally in the first few months, but giving baby too much water can cause seizures.

At four months, it is time to introduce cereal. Start with a simple single grain cereal such as rice. Feed baby cereal with a spoon from a bowl; avoid adding cereal to the bottle. After rice, try other grains, and eventually mixed grain cereal after you have introduced each grain by itself. Hot cereals such as farina or oatmeal can be introduced at around six months.

After six months, baby is usually ready to really start eating. He should be able to sit well with support and spoon feeding should be well under way. Start with finely pureed or Stage One vegetables, then add fruits after introducing a few vegetables. Remember to introduce a new food every several days, instead of trying several new ones in one or two days. Take it slow and learn what baby likes. If he develops a rash or other reactions to a food, let your doctor know, it may be okay to try that food later when baby is older. Avoid using honey in the first year; and never give baby beverages such as coffee or soda pop.

Generally, it is recommended to delay the introduction of commonly allergic foods such as peanuts, fish, eggs, and chocolate until after age one year. In addition, children should not be given whole milk until they are one year old. Continue whole milk until age two years, and after age two, it is fine to switch to low fat milk such as 2 percent. Alternatives to whole milk include fortified rice or soy milk.

During baby's first year of life (but after four months of age), fruit juice should be limited to about four to six ounces per day. White grape juice tends to be tolerated well by most babies, but apple and pear juice are also good. Try citrus and mixed juices after one year of age.

Although everyone will seem to have an opinion about what your baby should eat, it is important to work closely with your pediatrician through the first year and beyond when it comes to your child's nutrition. Develop good eating habits early on, and set a good example for your children as well. A healthy balanced diet is the foundation for a healthy body and long healthy life.

Taking Care of Your Infant's Mouth

Beth McKinney R.D.H., M.S., Maternity and Child Health Dental Program, Montgomery County HHS

Congratulations on the birth of your new baby! This is a busy and exciting time in your life. Having a newborn in the house can also be overwhelming and a little scary. While you are worried about many things, the oral health of your new baby may seem like a minor concern. However, your baby's oral health determines in large part how well they are able to take in nutrition. Later on it will contribute to how well they learn to speak. Their facial appearance will also affect how they are perceived by their peers. Cavities and toothaches are a big reason for time lost from school.

Taking care of your baby's mouth is easy. First, a few words about your baby's mouth at birth: bumpy gums are normal. Occasionally infants are born with one or two teeth already present. These are usually removed for the comfort of the mother while breast-feeding. Cleft lips and palates are a common birth defect. Modern medical surgery has come a long way in being able to completely repair these defects; however, a few accommodations may be necessary so your baby can swallow properly prior to surgery.

Follow these few steps to assure your baby has a health mouth.

❖ Wipe your baby's gums once daily with a washcloth until teeth begin to arrive. It is easy to do this when you are giving your baby a bath. (Look for the first teeth at age six-eight months and a full set by two years of age.)

❖ When a number of teeth have appeared, switch to a baby toothbrush. Do not use toothpaste unless it is a non-fluoridated toothpaste designed to be eaten.

❖ If you give your baby a bottle, use fluoridated water to mix the formula. If you buy bottled water, make sure it contains fluoride.

❖ Never put your baby to bed with a bottle containing anything but plain water. Milk and juice left on the teeth will cause severe decay of the upper front teeth.

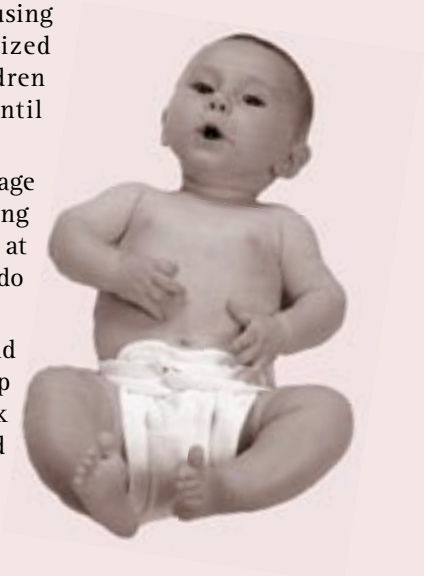
❖ Never give babies pacifiers that have been dipped into anything sweet.

❖ Don't worry too much about thumb-sucking until the permanent teeth begin to arrive (age five-six).

❖ At age two, when all the baby teeth are in, you may introduce the toddler to using the toothbrush with a small pea-sized amount of regular toothpaste. Children need supervision while brushing until about age six.

❖ The first dental visit should occur by age two. Some experts are now recommending by age one. Expect only a quick exam at this stage. Let the dental professionals do all the explaining to your toddler.

❖ Do not let your toddler run around during the day with a sippee cup containing anything but water. Milk and fruit juices should be consumed only at meals.



Study Modules Available to Help Health and Early Childhood Professionals Promote Oral Health for Infants and Young Children

Open Wide: Oral Health Training for Health Professionals is a series of four self-contained online modules designed to help health and early childhood professionals working in community settings (e.g., Head Start and WIC staff) promote oral health in the course of promoting general health for infants, children, and their families.

The modules were prepared by the National Maternal and Child Oral Health Resource Center and the Center for the Advancement of Distance Education at the University of Illinois at Chicago with support from the Maternal and Child Health Bureau. Topics include tooth decay, risk factors for tooth decay, and prevention of tooth decay; oral health risk assessment and oral health screening; and anticipatory guidance for parents.

Each module includes an overview, learning objectives, key points, a self-assessment quiz, online resources, and an evaluation form. A glossary and a list of presentations, print materials, and videotapes are also presented.

The modules are available at *www.mchoralhealth.org/OpenWide/index.*

Facts on Early Childhood Caries

Promoting Awareness, Preventing Pain: Facts on Early Childhood Caries (ECC), a fact sheet published by the National Maternal and Child Oral Health Resource Center (OHRC), presents information on dental caries in the primary teeth of children from birth through age five. The fact sheet defines ECC, describes who is at risk, and presents information on both the financial and the human costs of ECC. It also suggests ways in which health professionals can reduce a child's risk for ECC. The fact sheet is intended for use by health professionals, program administrators, policy makers, and others working to improve the oral health status of infants, children, and their families.

Available on the OHRC Web site at *www.mchoralhealth.org/PDFs/ECCFactSheet.pdf.*

All Women and Men Need Folic Acid Every Day

The risk of neural tube defects – birth defects of the brain (anencephaly) and spinal cord (spina bifida)—is significantly reduced when women get enough folic acid before they become pregnant. Folic acid may also help prevent certain types of cancer.

❖ The brain and spinal cord are formed during the first month of pregnancy before most women know they are pregnant. That's why it's important for women to get adequate folic acid throughout their childbearing years, even when not planning a pregnancy. Then, if a woman gets pregnant, her risk of having a baby with a serious defect of the brain or spinal cord is reduced.

❖ Women need to continue taking folic acid during pregnancy in their pre-natal vitamins.

❖ Men and post-menopausal women also need folic acid every day to reduce their risk of heart disease, stroke, and cervical or colon cancer.

How To Get Enough Folic Acid

Women who could possibly become pregnant need 400 micrograms (mcg) of folic acid every day. The same amount (400 mcg) is also recommended for men and post-menopausal women. Pregnant women need 600 mcg. Taking a multivitamin or eating foods fortified with folic acid, in addition to eating foods that contain the vitamin naturally, helps you get enough.

❖ Check with your health care provider or a registered dietitian about the need to take a daily multivitamin if you're not getting at least 400 mcg each day from the foods you eat.

❖ Cereals and other grain products (such as bread, pasta, and rice) fortified with folic acid are the best food sources of folic acid. You can get 400 mcg of folic acid every day by eating a cereal for breakfast that contains 100% of the "daily value" for folic acid. Read the label on the cereal box to find out how much folic acid it contains.

❖ Eating foods high in folate (the natural form of the vitamin) on a regular basis will also help you get folic acid. Some foods high in folate include:

- ✓ Kidney beans
- ✓ Split peas
- ✓ Broccoli
- ✓ Black beans
- ✓ Orange Juice
- ✓ Spinach
- ✓ Lentils
- ✓ Asparagus
- ✓ Other dark green leafy vegetables

Maryland Department of Health and Mental Hygiene, Family Health Administration, Center for Maternal and Child Health and the Office of the Maryland WIC Program

Little-Known Nutrient Linked to Fetal Development, Lowered Birth Defect Risk

The Wall Street Journal examined the nutrient choline, which plays a "critical role" in fetal brain development and might reduce the risk of neural-tube defects, such as spina bifida, in the same way as folic acid. The nutrient, which is found in large quantities in basic protein foods, such as eggs, chicken liver, beef, wheat germ and soybeans, aids in the transport of nutrients into and out of cells.

It also is involved with learning and memory functions and might regulate the division of stem cells that form the memory areas of the brain during fetal development. Although choline deficiency is "rare" among women who are not pregnant or breastfeeding, "enormous quantities" of the nutrient are "pumped across the placenta" during pregnancy and choline becomes 15 times as concentrated in a fetus as in a pregnant woman, according to Steven Ziesel, head of the Department of Nutrition at the University of North Carolina-Chapel Hill.

Large quantities of choline also are concentrated in breast milk, prompting FDA to require that all infant formulas contain the nutrient. However, the nutrient "has yet to find its way onto the public's radar screen."

Reprinted with Permission from the Kaiser Daily Reproductive Health Report

Increases in Immunization of Infants

A report released by the Centers for Disease Control and Prevention pointed to substantial increases nationwide in the percentages of young children ages 19 months to three years who received recommended childhood vaccinations in 2003, compared to 2002.

For example, there were increases in the percentages of children in that age group who had received more than one dose of varicella vaccine (VAR), which protects against chickenpox, and three doses or more of pneumococcal conjugate vaccine (PCV), which protects against a common cause of diarrhea in infants. Those are the two newest vaccines, and progress in giving them is welcome news, the CDC said.

For older vaccines, the National Immunization Survey of households found coverage with recommended vaccines was greater in 2003 than in 2002 and reached an all-time high. Here are the increases in some immunizations in 2003 compared to 2002:

❄ More than one dose of VAR (varicella vaccine)—increased from 80.6 percent of children in 2002 to 84.8 percent in 2003.

Three doses or more of PCV (pneumococcal conjugate vaccine)—increased from 40.9 percent in 2002 to 68.1 percent in 2003.

DTaP (diphtheria, tetanus, and pertussis)—96 percent of children had received three doses in 2003, compared with 94.9 percent in 2002. In 2003, 84.8 percent of children had received a recommended fourth dose of DtaP, compared with 81.6 percent in 2002. The apparent lag in fourth doses may have been caused by vaccine shortages.

Poliovirus, three doses—91.6 percent of children had received three doses in 2003, compared to 90.2 percent in 2002.

Measles, mumps, and rubella (MMR) —93 percent of children had received one dose or more in 2003, compared to 91.6 percent in 2002.

Although it covers only vaccinations given to children ages 19 months to three years, the report released July 30 has implications for the immunization levels schools can expect down the road. Approximately one million children are born each year in the United States, and maintaining vaccination coverage for so many individuals is a challenge, the CDC noted. The report also cautions that there is wide variability in coverage of children among states and urban areas, and it calls for "continued vigilance" to maintain high levels of coverage and to eliminate geographic disparities.

"National, State, and Urban Area Vaccination Coverage Among Children Aged 19-35 Months—United States, 2003", Morbidity and Mortality Weekly Report, July 30, 2004 Available online at *www.cdc.gov/mmwr.* See also *"Recommended Childhood Immunization Schedule, July-December 2004" at www.healthinschools.org/2004/july16_alert.asp*

Children Who Have Received No Vaccines

While the figures compiled by the Centers for Disease Control and Prevention show that most children are being vaccinated as infants, it still seems that as much as 10 percent of the child population is not immunized. In an article in the July 2004 issue of the journal Pediatrics, researchers asked who those children are, and why they have not been vaccinated.

The researchers stated that it is important to distinguish between children who have received no vaccinations and children who are under vaccinated. The never-immunized, they found, tended to be disproportionately white children whose mother was married, had a college degree, and lived in a household with an annual income exceeding $75,000. The under vaccinated (those who had received some but not all of the recommended immunizations) tended to be black, to have a younger mother who was not married and did not have a college degree, to be in a household near the poverty level with more than four children, and live in a central city.

Looking more closely at the never-vaccinated, the researchers suggested that those children may, in fact, never become vaccinated, and when they enter school will be "exemptors" who are excused for medical, religious, or philosophical reasons from the mandatory vaccinations required by most states and school systems. Unvaccinated children tend to be clustered in metropolitan areas in western states, although there are also large numbers in southern, eastern, and midwestern sections of the United States.

Other characteristics of never-vaccinated children include that they are 22 times more likely to contract measles and six times more likely to contract pertussis than vaccinated persons, and the majority of recent tetanus cases have been in unvaccinated children.

Why do some parents avoid vaccinating their children? According to the researchers, concerns about vaccine safety, and particularly perceived risks of autism, multiple sclerosis, and sudden infant death syndrome may motivate many parents, as do misperceptions about vaccination, including whether it inhibits development of the natural immune system.

Given that the number of never-vaccinated children appears to be increasing, with implications for "herd immunity" in schools, it is important to design and target programs aimed toward parents who choose for their children not to receive any vaccinations, the researchers suggested.

"Children Who Have Received No Vaccines: Who Are They and Where Do They Live?" Journal Pediatrics, July 2004.

Prevention of Perinatal Infections Chart

Baltimore Regional Perinatal Advisory Group

The Baltimore Regional Perinatal Advisory Group (RPAG) is a multidisciplinary group of health care professionals who are concerned about improving perinatal health in Baltimore County and Baltimore City. Members of the group represent both public and private sectors including universities, health departments, hospitals, patient advocacy groups, and health maintenance organizations (see overleaf). The RPAG's mission is to optimize the health of pregnant women and newborn infants in the Baltimore region through education, advocacy and information sharing. Established in 2002, the RPAG is supported in part by a grant from the Maryland Department of Health and Mental Hygiene, Center for Maternal and Child Health.

On the following page is an RPAG document that summarizes the latest screening recommendations for infections during pregnancy. It is available as a laminated sheet which can be posted so it is readily accessible to professionals in your office and provides a quick and comprehensive reference. The RPAG developed this tool to address the problem of perinatal infections and provide reminders of both long-standing and recent recommendations for perinatal infectious disease screening. The information on this sheet was derived from several sources including ACOG, the new CDC guidelines, and the Code of Maryland Regulations. For further details, please consult the source documents noted at the bottom of the sheet.

We hope you find this recommendation sheet useful in your practice. The recommendations are available on the Baltimore County Department of Health web site as a pdf file for downloading and reproducing: *www. Baltimorecountyonline. info/go/perinatal*. Please take the time to provide some feedback utilizing the attached sheet which can be sent by fax to Elisabeth Liebow, MPH, Project Director, and Coordinator of the Perinatal Infections Outreach Program at the Baltimore County Department of Health (contact information below).

Thank you for your assistance in improving maternal, fetal and infant health in the Baltimore region.

A project of the Perinatal Infections Outreach Program, Baltimore County Department of Health, 6401 York Road, 3rd Fl. Baltimore, MD 21212
Ph: 410-887-3134 Fax: 410-377-5397

Cervical Cerclage Does Not Substantially Prevent Premature Delivery in Women With Short Cervices

Pregnant women with short cervices—who have an increased risk of premature delivery—who undergo the common practice of cerclage are only slightly less likely to deliver preterm than women with short cervices who do not undergo the procedure. Cervical cerclage, which involves stitching the cervix closed, has been widely used for the past 50 years to prevent preterm birth, which is associated with increased infant mortality and illness.

Kypros Nicolaides of Kings College Hospital in London and colleagues identified 250 women with short cervices and randomized them to receive either cerclage or no surgery. Approximately 22 percent of the cerclage group delivered before 33 weeks gestation, compared with 26 percent in the group that did not receive surgical intervention, according to the study. In addition, there were no significant differences in maternal or perinatal morbidity or mortality, according to the study. However, the proportion of women who delivered preterm in both groups was "far higher" than the 1.5 percent average rate of preterm delivery in the United Kingdom, the study said.

The researchers concluded that the procedure—which carries an increased risk of infection and tearing if the stitching is still in place when labor begins —seems to have a limited effect on women with small cervices. However, Nicolaides said that routine sonograms of cervical length at 22 weeks to 24 weeks gestation can help identify women with short cervices who are at especially high risk of preterm delivery.

Lancet 2004; 363: 1849-53

PREVENTION OF PERINATAL INFECTIONS

The Baltimore Regional Perinatal Advisory Group

TIMING	PROCEDURE	INDICATION
1ST PRENATAL VISIT	STS/RPR/VDRL	**REQUIRED** under Code of Maryland Regulations (COMAR 10.06.01.17)[1]
	HIV counseling/offer HIV testing	**REQUIRED** under Annotated Code of Maryland. Health-General Section 18-338.2
	HBsAg	RECOMMENDED[1,2,3]
	Rubella IgG antibody	RECOMMENDED[3]
	GC detection	RECOMMENDED[1]
	Chlamydia detection	RECOMMENDED[1]
	Test for BV (or diagnose clinically)	RECOMMENDED by some experts for pregnant women at risk for preterm labor[1]
	Pap	RECOMMENDED[3]
	Urine culture/screen	RECOMMENDED[3]
	Anti-HCV	RECOMMENDED for women at risk for exposure[1]
	Elicit history for possible exposure to genital herpes	RECOMMENDED[1]
	Determine varicella immune status (history or lab)	RECOMMENDED[3]
28 WEEK VISIT (EARLY 3RD TRIMESTER)	RPR/STS/VDRL	**REQUIRED** under COMAR 10.06.01.17
35-37 WEEK VISIT (LATE 3RD TRIMESTER)	HIV counseling/HIV testing	RECOMMENDED if unscreened previously, or negative at first trimester screen and at high risk of infection[1,3,6]
	GBS culture (rectovaginal)	Universal screening approach RECOMMENDED for all pregnant women[3,4]
	GC detection	RECOMMENDED again in the 3rd trimester only for women at high risk of infection[1,3]
	Chlamydia detection	RECOMMENDED again in the 3rd trimester only for women at high risk of infection[1,3]
	HBsAg	RECOMMENDED again in the 3rd trimester only for HBsAg-negative women at high risk of infection[1,3]
LABOR & DELIVERY	RPR/STS/VDRL	RECOMMENDED for all women at continued risk[1] **REQUIRED** in Baltimore City for all deliveries under Health Commissioner's Order and statewide under COMAR 10.06.01.17 for deliveries with no prenatal care
	HIV counseling/HIV testing	RECOMMENDED for women not previously screened, or if status unknown or undocumented [1,6]
	HBsAg	RECOMMENDED for women not previously screened, or if status unknown or undocumented[2,3]
	GBS - Treat if culture positive at 35-37 weeks; if status unknown, treat by risk-factor criteria	RECOMMENDED[4,5]
	Genital Herpes - Obtain history and examine genitalia for herpetic lesions	RECOMMENDED[1, 3]

1 Guidelines for the Treatment of Sexually Transmitted Diseases 2002 (CDC, MMWR, May 10, 2002/Vol. 51/No. RR-6) for management of positive results. http://www.cdc.gov/mmwr/PDF/rr/rr5106.pdf

2 Hepatitis B Virus: A Comprehensive Strategy for Eliminating Transmission in the United States Through Universal Childhood Vaccination: Recommendations of the Immunization Practices Advisory Committee (ACIP) (CDC, MMWR, Nov. 22, 1991/Vol. 40/No. RR-13) for management of positive results. http://www.cdc.gov/mmwr/preview/mmwrhtml/00033405.htm

3 Guidelines for Perinatal Care. American Academy of Pediatrics; American College of Obstetricians and Gynecologists. October 2002.

4 Prevention of Perinatal Group B Streptococcal Disease: Revised Guidelines from CDC (CDC, MMWR, Aug. 16, 2002/Vol. 51/RR-11) for management of positive results. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5111a1.htm

5 Prevention of Early-Onset Group B Streptococcal Disease in Newborns. ACOG Committee Opinion No. 279. American College of Obstetricians and Gynecologists. Obstetrics and Gynecology 2002;100:1405-12.

6 Revised Recommendations for HIV Screening of Pregnant Women (CDC, MMWR, Nov. 9, 2001/Vol. 50/No. RR-19) http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5019a2.htm

For additional copies, contact The Perinatal Infections Outreach Program, Baltimore County Department of Health, 410-887-3134.

Supported in part by a grant from the Maryland Department of Health and Mental Hygiene, Center for Maternal and Child Health. January 2004

MCPS Pre-kindergarten/Head Start Programs

Lisa Conlon, LCSW-C, Social Services Supervisor, Pre-Kindergarten/Head Start Unit, Rocking Horse Road Center, Montgomery County

The Montgomery County Public Schools Pre-kindergarten/Head Start Programs serve over 2,600 low income three- and four-year-old students and their families in Montgomery County. Our program offers half-day pre-kindergarten and Head Start classes in the public schools. The curriculum is research-based, incorporating best practices for early education. The curriculum has a literacy-focus and is aligned with the Montgomery County Public Schools' kindergarten curriculum.

From studies on early brain development, we know that early education is vitally important and that children learn best through experiences that have meaning for them. Children learn through their senses so play, music, movement, and art are critical. The education offered in our Pre-kindergarten/Head Start Program focuses on the seven developmental domains of the Maryland Model for School Readiness: social-emotional, scientific thinking, mathematical thinking, language and literacy, physical and motor, social studies and the arts to ensure a well-rounded foundation for future learning in kindergarten and beyond.

The Pre kindergarten/Head Start Program offers health, dental, and nutrition services including screenings and health/nutrition education. The Pre-kindergarten/Head Start Program promotes family and community partnerships by involving parents in the classroom, at home, and in program management. In addition, 25 family service workers home visit families and provide individual support and case management, as well as parent meetings on a variety of topics.

Social workers provide more intensive family support when needed. Key to our success is collaboration with other early childhood programs and agencies in the community, including Health and Human Services, members of the home visiting consortium (including Early Head Start, Infants and Toddlers, Healthy Families Montgomery, Families Foremost), Judy Centers, and other community partners. By involving and supporting parents, collaborating with community partners, and providing quality early education our students are ready for kindergarten and a successful future.

Indicators of Early Child Development and Health

Early Child Development in Social Context: A Chartbook reviews more than 30 indicators of development and health for infants and children from birth through age six, as well as factors in families and communities that affect children's development and health. The project was commissioned by the Commonwealth Fund and undertaken by Child Trends in partnership with the American Academy of Pediatrics' Center for Child Health Research.

Topics include socioemotional development, intellectual development, child health, family functioning, parental health, health care receipt, community/neighborhood factors, child care, and demographic factors. In addition to presenting data, the chartbook includes brief research-based explanations of the importance of the indicators and considers possible steps policy makers, practitioners, and parents can take to improve children's development and health.

The chartbook is available at *www.cmwf.org/usr_doc/ChildTrends-Chartbk2004h.pdf.*

Head Start

Beginning Early for Success

The Tri-County Baby Net Project

Rose Johnson, MCH Program Director, Wicomico County Health Department

Baby Net is a program designed to assure access to prenatal care for the uninsured undocumented pregnant women in the Tri-County region (Somerset, Wicomico and Worcester) of the Eastern Shore. The Lower Shore Perinatal Council, a voluntary community-based, collaborative partnership, was established in 1997 when HealthChoice was implemented and local health departments closed prenatal clinics. Uninsured pregnant women lacked access to prenatal care. In 1998, the LSPC created Baby Net as response to this need.

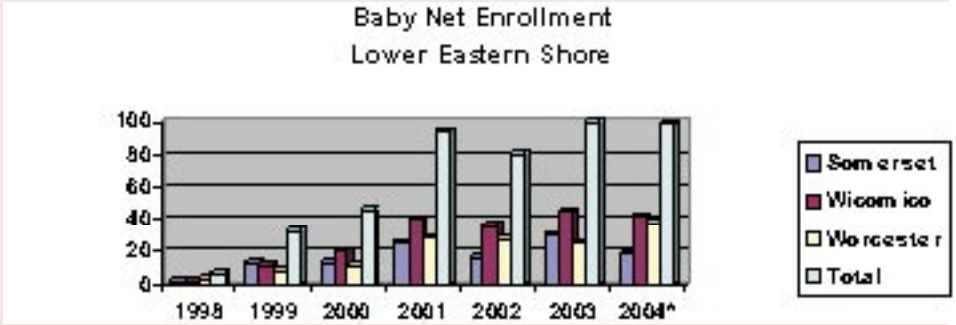
Baby Net is supported by a regional partnership of private and public organizations including: Three Lower Counties, Inc., (TLC—a federally qualified health center), Seton Center, obstetricians, Apple Pharmacy, Peninsula Regional Medical Center and Somerset, Wicomico and Worcester County Health Departments. The LSPC received the "Outstanding Rural Health Program" award for Baby Net from the Rural Health Association in 1999.

In 2001, the LSPC was awarded the Crenshaw Perinatal Health Phase IV grant from the Department of Mental Health and Hygiene (DHMH) to support administration and coordination of the program. The LSPC also received a grant from the March of Dimes to provide limited diagnostic and laboratory testing services for Baby Net participants.

Elements of Baby Net include:

- Local health departments screen pregnant women for MCHP eligibility
- Eligible pregnant women are assigned to a participating obstetrician on a rotating basis to prevent overwhelming any particular practice
- Co-pays for some services are required of participants
- TLC handled financial and billing component of program
- PRMC provided charity care based on eligibility
- Prenatal vitamins and limited diagnostic and testing services funded
- Community case management through health department home visiting programs to at-risk women

Since its inception in 1998, over 460 pregnant women have been enrolled in Baby Net. Since 2000, enrollment has dramatically increased:



The majority of women served in Baby Net are of Hispanic ethnicity. Based on delivery outcome data for FY02 through FY 04, 89 percent of all Baby Net women entered care by the second trimester and 95 percent delivered a baby weighing >2500 grams (or + 7lbs.). Recently, TLC has been able to contract directly for OB services with a local OB/GYN practice group.

All Baby Net women are currently seen at TLC for prenatal care. Interpreters are available at each visit and transportation is provided to assure access. Participants now pay for their labs and visits on a sliding fee scale (some will still only pay a minimum co-pay), while local health departments continue to provide case management services. With this new system of care, the LSPC will continue to closely monitor any changes in outcomes.

Para La Salud de Madres y Niños

Journal Resource on Children of Immigrant Families

The Fall 2004 issue of The Future of Children, titled Children of Immigrant Families, examines the strengths and challenges that set children of immigrant families apart from the mainstream population.

The journal, published by the David and Lucile Packard Foundation, includes articles that summarize research on demographic shifts, economic and labor market trends, and child health and development. It also includes a series of responses from experts on how policy makers, advocates, stakeholders, and practitioners can respond strategically and pro actively to demographic change and increasing diversity to promote the healthy development, productivity, and well-being of immigrant children in the future.

The journal is available at *www.futureofchildren.org/pubs-info3775/pubs-info.htm?doc_id=240166.*

ChildLink—Montgomery County Early Childhood Public Engagement Project

Beth Molesworth, Program Manager, Children's Resource Center, Montgomery County

The needs of the callers to the ChildLink program are varied, but here are two examples of the types of calls ChildLink receives, and how the program met the needs of the callers.

▼ A young mother called looking for services for her two year old: the child had just been diagnosed with Type 1 diabetes and she had concerns about the child's development. In addition, the mother wanted to update immunizations for her four other children. The family also needed clothing and help paying rent and electric bills. With a single call, this mother was able to complete an intake for the two year old for the Infants and Toddler's Program and to receive information about Rental Assistance, MEAP, and the Immunization Clinic.

▼ A caller had specific questions on preparing for the arrival of a new baby. She thought she might be pregnant and was concerned because her husband's insurance would not cover her prenatal care. She was worried that she might not qualify for medical assistance. Her English was limited and she was not sure how to get help. The bilingual ChildLink counselor assisted her in making an appointment at the Regional Health Center where her pregnancy was confirmed. She also applied for medical assistance and in a follow up call was happy to share the good news with the counselor that she qualified for insurance.

ChildLink serves Montgomery County as a single point of entry where bilingual counselors can triage calls, make referrals, and provide information and linkages to a wide variety of programs and services for young children and their families. Calls range from the simple, such as "How do I find out about child care?" to complex, requiring counseling, multiple follow up calls and referrals to health, mental health early intervention, family support, and social services agencies. In FY04, the first full year of ChildLink's operations, 1333 callers were served with referrals to 481 programs. One hundred thirty seven agency/program representatives called for information about services for young children. Eighteen percent of callers received services in Spanish.

ChildLink is the centerpiece of Montgomery County's Early Childhood Public Engagement efforts. Based on the Early Childhood Comprehensive Plan developed by over 100 representatives from public and private agencies serving children and families, public engagement and outreach to the community was seen as essential to achieving the long term outcomes of "All Children will be Ready for School." Focus groups of parents and caregivers repeatedly requested "one number" where they could get information about the full range of services available to families with children birth to age five. ChildLink—240-777-4769—was the result.

Another key element of the public engagement campaign was the creation of a "brand" for Montgomery County's early childhood programs. The logo "Help Me Grow" now serves as an umbrella for a number of local early childhood activities, including packets of resources for parents with newborns, Month of the Young Child family festivals, training for child care givers, and "Learning Parties" for parents in targeted communities to assist them in working with their children on preliteracy skills.

Bilingual ChildLink fliers and Help Me Grow materials are now available in hospitals and Ob/Gyn offices throughout Montgomery County, health clinics, social services waiting rooms, child care programs, and at many fairs and events targeted toward families.

For more information on ChildLink or help me grow efforts, call 240-777-GROW (240-777-4769).

Healthy Start Activities in Washington County

Washington County's Healthy Start program has been active in accomplishing the following innovative steps to assist their clients:

❉ A grant was obtained to hire a part-time LCSW social worker to home visit clients who are depressed to do therapy in the home. For clients with other mental health issues, the social worker assists with linkage to other mental health services.

❉ A grant was applied for and $1000 awarded from Walmart in the form of 50 $20 gift certificates. These certificates are used as an incentive for women to keep their appointments with their Healthy Start nurse. The certificates are given at the postpartum visit.

❉ Used cell phones are collected from the Health Department staff and offered to women who have no phones for 911 use, either for emergency medical problems or for domestic violence issues if they are not yet involved with our local domestic violence agency.

Ginny Emerson, Supervisor, Washington County Health Department

◆ ◆ ◆ ◆

Measuring Quality in Child Health Care Programs

Child Health Care Quality Toolbox (formerly Child Health Toolbox) contains concepts, tips, and tools for evaluating the quality of health care for children. The redesigned toolbox, a product of the Agency for Health Care Research and Quality, enables users to download to their desktops all sections of the toolbox, including a new section on mental health measures. Other sections include information on uses of quality measurement, established child health care quality measures, emerging quality measures, choosing quality measures, how to develop quality measures, and resources. The toolbox is available at *www.ahrq.gov/chtoolbx.*

Asthma Symptoms Increases Risk of Preeclampsia

Pregnant women with moderate to severe asthma symptoms are more likely to develop preeclampsia than those with no asthma symptoms, according to a study published in the journal Obstetrics and Gynecology. Dr. Elizabeth Triche of Yale University School of Medicine, and colleagues, studied the hospital records of 1,708 pregnant women, of whom 656 had diagnosed asthma and 1,052 did not. The researchers used the Global Initiative for Asthma guidelines to classify asthma symptoms, type and severity.

The researchers found that "having a self-reported diagnosis of asthma does not increase the risk of preeclampsia; rather, it is having active asthma symptoms through pregnancy that increases the risk." Overall severity of asthma or having physician-diagnosed asthma did not increase the likelihood of developing preeclampsia. However, the frequency of asthma symptoms during pregnancy was related to increased risk of preeclampsia.

Women with daily symptoms of asthma were three times more likely to develop preeclampsia than those without symptoms, according to the study. The findings suggest that patients with asthma symptoms, with or without an asthma diagnosis, should be closely monitored during their pregnancies. Past studies of a link between asthma and preeclampsia have revealed inconsistent results, perhaps due to difference in study populations, varying definitions of asthma and asthma medication use. The "hallmarks" of preeclampsia during pregnancy are high blood pressure and impaired kidney function.

Obstetrics and Gynecology, 2004;104:585-593

Asthma—

A Complicating Factor

Untreated Asthma in Pregnant Women Increases Risk of Reduced Fetal Growth in Female Fetus

Women with asthma who are pregnant with a female fetus and do not use inhaled steroids to treat their asthma, have an increased risk of delivering an infant with reduced growth, according to a study published in the Dec. 1 issue of the *American Journal of Respiratory and Critical Care Medicine*. Dr. Vicki Clifton, and colleagues at John Hunter Hospital in Newscastle, Australia, studied 138 pregnant women with asthma and 44 pregnant women without asthma. The researchers determined the levels of various hormones at delivery and measured the activity of an enzyme that prevents maternal levels of the enzyme cortisol from reaching the fetus.

Among participants with untreated asthma, the researchers observed significantly reduced birthweights in female infants but not in male infants. The finding holds true regardless of the pregnant woman's asthma severity or smoking status. In addition, pregnancy with a female fetus was associated with an increased level of maternal immune cells, reduced activity of cortisol and an increase in fetal cortisol levels.The reduced growth of the fetus occurs because "some unknown factor" produced by a female fetus increases inflammation in the pregnant woman. The researchers conclude, "By examining the endocrine and immune relationships between mother, placenta and fetus during asthmatic pregnancies, this study has provided strong evidence for a detrimental effect of maternal inflammation on placental function and female fetal growth and development."

Maternal Asthma Is Associated with Reduced Female Fetal Growth.

American Journal of Respiratory and Critical Care Medicine Vol 168. pp. 1317-1323, (2003)

Addressing Needs of Drug-Affected Newborns

Carolyn W. Colvin, Director, DHHS, Montgomery County

Effective June 30, Federal reauthorization and amendment of the Child Abuse Prevention and Treatment Act (CAPTA) required states to develop policies and procedures to address the needs of infants born and identified as affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure. Also included is the requirement that health care providers involved in the delivery of care to such infants notify the child protective services system of the occurrence of such conditions. Importantly, notification will not be construed to constitute child abuse or to require prosecution. The CAPTA provisions further require states to develop "procedures for the immediate assessment of risk and safety of infants born and identified as being affected by illicit substance abuse or withdrawal symptoms" and to have in place a "plan of safe care for these infants."

Maryland is addressing the requirements of the legislation through its local departments of social services. Montgomery County Department of Health and Human Services/Child Welfare Services (MCDHHS/CWS) will accept referrals of newborn infants of county residents who are affected by illegal drugs or have withdrawal symptoms. Such referrals should be made to the CWS Screening Unit at 240-777-4417 and must be accompanied by the Drug-Exposed Newborn Reporting Form, which should be faxed to the CWS Screening Unit at 240-777-4258 at the time of the report. The reporting form will provide a uniform and consistent format to document risk factors as identified by hospital staff. MCDHHS/CWS has provided hospitals with the Drug-Exposed Newborn Risk Matrix to assist hospital staff in making comprehensive assessments of the risk and protective factors in a family. Additionally, a collaborative team of individuals involved in community health will be established and meet at regular intervals to update the status of referrals, identify service gaps and/or systems' initiatives in order to enhance and reduce risk to identified newborns and their families.

MCDHHS/CWS has identified a Drug-Affected Newborn Care Plan Coordinator who is available to respond to any questions or concerns reporters may have, and provide guidance and support to address the needs of drug-affected infants and their families. The DHHS/CWS Coordinator, Gayle Emen, may be contacted at 240-777-3390. Ms. Emen will also arrange to meet with hospital staff to discuss the new reporting requirements and the means to assess the risk and safety factors in identified families.

Contact your local Department of Social Services to find out what is going on in your county.

Official notification will not be construed as child abuse.

Is there a link between periodontal disease and preterm birth?

Mounting evidence suggests that a chronic oral infection may lead to an immune reaction that either triggers premature parturition or contributes to its onset. Each year over 400,000 infants are born prematurely as a result of preterm labor, preeclampsia, and other adverse events. In fact preterm birth (less than 37 weeks gestation) is the leading cause of neonatal mortality in the United States, affecting 11 percent of all live births. And while preterm birth, as a result of preterm labor, contributes to approximately two thirds of the cases of prematurity, we still do not fully understand what signals the onset of labor in these women. Both preventive and treatment efforts have been disappointing: The preterm birth rate remains unchanged after 30 years.

Clinical infections distant from the uterus, including shigellosis and urinary tract infections, have likewise been associated with preterm birth. Infections more proximate to the reproductive tract, such as BV, trichomoniasis, and Chlamydial cervicitis, seem to increase the risk of preterm birth. Intrauterine infection and chorioamnionitis also increase the risk of prematurity.

In the last decade, many investigators have been interested in studying the role of subclinical maternal infection in preterm labor. Evidence to support this theory includes the following: increased histologic chorioamnionitis in preterm births; increased clinical infection after preterm birth; a significant association between some lower genital tract organisms and infections and preterm birth or preterm premature rupture of the membranes; positive cultures of amniotic fluid or membranes from some patients with preterm labor and preterm birth; infection markers seen in preterm birth; induction of preterm birth in animal models by bacteria or their products; and finding in some clinical trials that antibiotics lower the rate of preterm birth or can defer preterm birth.

Exciting new data also suggest that chronic oral infection like periodontal disease may contribute to preeclampsia, preterm birth, fetal growth restriction, and fetal loss. Periodontitis, an oral

Continued on next page....

Relationship Between Periodontal Disease and Early Spontaneous Preterm Birth

Study researchers have demonstrated an association between severe periodontal disease and spontaneous preterm birth at less than 32 weeks of gestation. Although recent studies in the United States have demonstrated an association between maternal periodontal disease and multiple adverse pregnancy outcomes, the mechanisms by which periodontal disease and pregnancy outcomes are associated are not clear. The relationship between maternal periodontal disease and both early spontaneous preterm birth and selected markers of upper genital tract inflammation are examined.

The study population was a convenience sample of women enrolled in an ongoing study of risk factors for preterm birth at the Perinatal Emphasis Research Center at the University of Alabama at Birmingham. A periodontist conducted a dental examination for 59 women who had experienced a spontaneous preterm birth at less than 32 weeks of gestation, for a control population of 36 women who had experienced an indicated preterm birth (delivery for maternal or fetal indications) at less than 32 weeks of gestation, and for 44 women who had experienced an uncomplicated term birth. Cultures of the placenta and umbilical cord blood, cord interleukin-6 levels, and histopathologic examination of the placenta were performed for all women. A trained obstetric research nurse recorded maternal demographic, intrapartum, delivery, and postpartum information.

Results of the study include:

- ❑ The spontaneous preterm birth group had significantly more extensive periodontal disease than the term birth group (i.e., more areas of the mouth were affected).
- ❑ The spontaneous preterm birth group had more extensive periodontal disease than the indicated preterm birth group, but the threshold was not statistically significant.
- ❑ The spontaneous preterm birth group had higher rates of severe periodontal disease than the indicated preterm birth group or the term birth group.
- ❑ After controlling for maternal age, race, education, insurance status, parity, history of a spontaneous preterm birth, and smoking, women with severe periodontal disease were almost three times as likely to experience a spontaneous preterm birth as those without severe periodontal disease.
- ❑ There was no association between markers of upper genital tract inflammation at the time of birth and moderate-to-severe periodontal disease in cases of spontaneous preterm birth, indicated preterm birth, or term birth.
- ❑ Organisms that are known periodontal pathogens were identified by placental culture in only five women.

The authors conclude that further investigation into the potential etiology of the association between periodontal disease and preterm birth is warranted.

Goepfert AR, Jeffcoat MK, Andrews WW, et al. 2004. Periodontal disease and upper genital tract inflammation in early spontaneous preterm birth. Obstetrics & Gynecology 104(4):777-783.

More information is available from the National Maternal and Child Oral Health Resource Centers prenatal/perinatal bibliography at *www.mchoralhealth.org/materials/action.lasso?-database=Biblio&-layout=Web&-response=results.lasso&-MaxRecords=all&-DoScript=OHRCPre&-search.*

gram- negative anaerobic infection, is common in women of childbearing age. It presents as infection and inflammation of the gingiva and local support structures of the teeth, resulting in the destruction of the structures supporting the tooth. Fluid that bathes the tooth at the gingival margin, known as gingival crevicular fluid, often contains inflammatory mediators and the oral pathogens associated with periodontitis. The mechanisms underlying this destructive process involve both direct tissue damage resulting from plaque bacterial products, and indirect damage through bacterial induction of the host inflammatory and immune responses.

While periodontitis is a chronic, local oral infection, there is evidence that both local and systemic inflammation may occur. In addition, periodontitis has recently been recognized as a risk factor for the development of atherosclerosis and rheumatoid arthritis.

In 1996, researchers first reported an association between maternal periodontal disease and delivery of a preterm infant.The adjusted odds ratio for delivery of a preterm, low-birthweight (LBW) infant was seven (i.e., about a sevenfold increased risk) suggesting that periodontal disease may be a previously unrecognized and clinically significant risk factor for delivery of a preterm LBW infant. Extrapolation from these data suggested that 18 percent of the preterm, LBW infants born annually might be attributable to periodontal disease, which may thus account for a significant proportion of the $5.5 billion annual hospital costs associated with the care of small babies.

Extracted from the full article by Kim A. Boggess, MD in *Contemporary OB/GYN, August, 2003*

For the full article, go to: *www.contemporaryobgyn.net/obgyn/*and do a site search in past issues under the article title.

Excess Thyroid Hormone During Pregnancy Can Lead To Increased Risk of Miscarriage, Low-Birthweight Infants

Women who have an excess of thyroid hormone during pregnancy have an increased risk of miscarrying and delivering lower-birthweight infants, according to a study published in the *Journal of the American Medical Association*. Dr. Samuel Refetoff and colleagues at the University of Chicago and the Hospital Divino Espirito Santo in Ponta Delgada, Azores-Portugal, studied 167 members of one family in the Azores islands, some of whom are affected by a genetic mutation that causes excess thyroid hormone production without the usual symptoms associated with the condition. The researchers found that women affected by the mutation were three times more likely than women who did not have the mutation to miscarry and were more likely to deliver low-birthweight infants.

However, the affected women were not at an increased risk of premature labor, preeclampsia, stillbirth or perinatal loss. The researchers concluded, "Given the established importance of providing thyroid hormone replacement to even mildly hypothyroid pregnant women, it is important to recognize that over-replacement appears to be equally detrimental."

Finding Balance

The researchers' conclusion creates a "bedeviling problem" for the 10 percent of women of childbearing age who have thyroid problems. While too much of the hormone can lead to miscarriage and low-birthweight infants, too little of the hormone can affect fertility and lead to miscarriage and birth defects, including mental retardation. The study "calls into question" recent research that suggested all women with hypothyroidism should increase their doses of hormone replacements by 30 percent when they become pregnant. "Although the risks of insufficient thyroid hormone during pregnancy are established, we have not, until now, been able to determine the consequences of an excess," Refetoff said, adding, "We now see that having too much is just as bad as having too little."

Refetoff suggested that pregnant women's thyroid levels be monitored on an individual basis and be adjusted accordingly to maintain normal levels, However, Prakash Abraham, assistant secretary of the British Thyroid Association, said he would "not be alarmist" about the findings, adding, "These women studied were a small group and, because of their genetic background, I suspect they are exposed to much higher levels of hormone than would be given to women treated with thyroid hormone for hypothyroidism."

Journal of the American Medical Association, 2004; 292:691-695.

Women Taking Depo Provera at Increased Risk of Contracting A STD

In a study funded by the National Institute of Child Health and Human Development and USAID, researchers found that women who use the injectable hormonal contraceptive Depo Provera are more than three times as likely to contract the sexually transmitted diseases chlamydia and gonorrhea than women who do not use hormonal contraceptives Charles Morrison of Family Health International and colleagues enrolled 819 women ages 15 to 45 at two Baltimore-area Planned Parenthood clinics, all of whom were just beginning a contraceptive regimen. Of the women enrolled, 354 opted for oral hormonal contraceptives, 114 chose to use Depo Provera and 351 selected non-hormonal contraceptive methods.

At three, six and 12 months following enrollment, researchers tested each of the women for chlamydia and gonorrhea. At the end of the 12-month period, 45 women tested positive for one of the two STDs. Women using Depo Provera were about 3.5 times more likely to have contracted one of the STDs, compared with women who had been using non-hormonal contraceptives.

Women using oral contraceptives were 50 percent more likely to contract one of the infections, compared with non-hormonal contraceptive users; however, there were so few cases of the STDs among oral contraceptive users that the finding could have been coincidental. Although more research is needed to confirm the findings the study highlights the need for women who use hormonal contraceptives to also use condoms.

Hormonal Contraceptive Use, Cervical Ectopy, and the Acquisition of Cervical Infections.

Sexually Transmitted Diseases. 31(9):561-567, September 2004.

Teen Girls Uninformed, Misinformed About Pap Tests, Pelvic Exams

Few teenage girls know what a Pap test is or how it differs from other gynecological exams, according to a study published in the October issue of the *Archives of Pediatrics & Adolescent Medicine*. Diane Blake and colleagues at the University of Massachusetts Medical School asked 111 teenagers ages 14 and older attending UMass Memorial's adolescent clinic in Worcester, Mass., and any mothers accompanying their daughters to complete a survey examining their understanding of gynecological exams and Pap tests, which are performed as part of a pelvic exam to detect early signs of cervical cancer.

In the survey, participants were asked to write a definition of a Pap test and identify whether a Pap test is equivalent to a pregnancy test, a test for sexually transmitted diseases, a cervical cancer screening, a pelvic exam or a check up. Three of the 111 teens surveyed provided the correct definition of a Pap test, and two of those respondents correctly responded that the test is the same as a cervical cancer screening. The third respondent said that a Pap test is equivalent to an STD test, a pelvic exam or a cancer screening. More than two-thirds of the teen respondents indicated that they believed a Pap test is equivalent to a pelvic exam.

In addition, only 40 percent of the mothers could properly define a Pap test. According to the study, teens whose mothers accompanied them to the clinic were more likely to have little or no understanding of the Pap test, and more girls who had had intercourse said they believed a Pap was equivalent to a pelvic exam or STD test than girls who were not sexually active. Confusing the exams could cause trouble if a patient asks for one test when she really wants another test or believes she has had screening for STDs when she has not, the authors said, concluding that teenagers should receive more education about the meaning of a Pap test to make sure that sexually active teenagers do not mistakenly delay routine pelvic exams and STD screenings.

Archives of Pediatrics & Adolescent Medicine, Vol. 158 No. 10, October 2004

State Health Education Integration Activities Advancing Adolescent Health

Preventing HIV, STD, and Teen Pregnancy in Schools: Strengthening State Health and Education Agency Partnerships summarizes a July 2003 regional stakeholders meeting that aimed to strengthen collaboration between state departments of education and health to improve HIV, STD, and adolescent pregnancy prevention in schools.

The project and meeting report are a collaboration of the Association of Maternal and Child Health Programs; the National Alliance of State and Territorial AIDS Directors; the National Coalition of STD Directors; and the Society of State Directors of Health, Physical Education and Recreation with support from the Centers for Disease Control and Prevention's Division of Adolescent Health.

The two-day meeting brought together state teams of health and education agency staff to articulate a shared vision, describe state program assets, identify challenges, and name collaborative strategies. The report provides a summary of the meeting process and proceedings and samples of participants' shared experiences.

The report is available at *www.amchp.org/aboutamchp/publications/rsm%20report.pdf.*

Montgomery County Department of Health and Human Services

Phone Resource List

COMMUNITY HEALTH SERVICES AREA HEALTH CENTERS AND SEUs

Silver Spring Health Center/SEU
8630 Fenton St., 10th Floor
Silver Spring, MD 20910
Main Phone: 240-777-3160
SEU: 240-777-3066

Piccard Drive Health Center
1335 Piccard Drive
Rockville, MD 20850
SEU: 240-777-3120

Germantown Health Center
12900 Middlebrook Road
Germantown, MD 20874
Main Phone: 240-777-3380
SEU: 240-777-3591

HEALTH AND HUMAN SERVICES CLIENT SERVICES CENTER

Birth and Death Records
240-777-1755

Child Protective Services
240-777-4417
Crisis Center
240-777-4000

Immunization Program
240-777-1050

Hearing Clinic
240-777-3987

Women's Cancer Control
240-777-1750
Spanish Line
240-777-4549

HealthChoice/Medical Assistance
Client Services Center
240-777-1635
In Spanish: 800-504-7081
Provider Hotline
1-800-766-8692

Ombudsman
240-777-8614

Other Information
1-800-492-5231

Community Clinic, Inc.
W.I.C.
301-762-9426

HealthChoice Information
1-800-492-5231

Community Clinic, Inc.
Gaithersburg (301) 216-0880
Silver Spring (301) 585-1250
Hyattsville (301) 431-2972

Mobile Medical
301-493-2400

TEEN HELP

Healthy Kids and Pregnancy Assistance
240-777-1616 or 8614

Perinatal Information (Spanish)
1-800-504-7081

Holy Cross Hospital Prenatal Clinic
301-754-7630

Child Care Health Line
301-777-8980

MCDHHS Help Line
240-777-4000

Child Care Vouchers
240-777-1155

PREGNANCY COUNSELING

Birthright
301-946-3339

Catholic Charities
301-434-2550

Shady Grove Pregnancy Center
301-963-6223

Rockville Pregnancy Aid Center
301-770-4444

FAMILY PLANNING

Family Planning Factline
202-638-3228

Montgomery County Information
240-777-1000

Natural Family Planning Center
301-897-9323

Planned Parenthood
301-208-1300 (Gaithersburg)
301-608-3448 (Silver Spring)

Emergency Contraception Hotline
1-800-584-9911

Teen Connection of Takoma
301-891-0977

STD
240-777-1760

HIV Client Services
240-777-7681

HIV/AIDS information
240-777-1869

EDUCATIONAL/VOCATIONAL SERVICES

MCPS Home and Hospital Teaching
301-657-4963

GED
301-929-6961

SUPPORT PROGRAMS

MCPS Teen Parent Support Program
240-777-1570

MCPS Information Line
301-279-3391

MOMS Program
301-424-0656

Bethesda Youth Services
301-229-1347

Rockville Youth Services
301-309-3390

Gaithersburg Guide
301-590-9864

Silver Spring HELP
301-585-4357

Germantown HELP
301-482-1320

Upper Montgomery HELP
301-972-8481

MANNA Food Center
301-424-1130

7th Day Adventist Community Services
301-585-6556

Salvation Army
301-948-1947

CRISIS COUNSELING

HHS Crisis Center (24 hour)
240-777-4000
TTD: 240-777-4815

HHS Victim Assistance and Sexual Assault Crisis Line
240-777-4357

HHS Abused Persons Crisis Line
240-777-4673

Maryland Youth Crisis Hotline
1-800-422-0009

National Youth Crisis Hotline
1-800-448-4663 (HIT HOME)

Alcoholism Referral and Information
1-800-527-5344

Cocaine Hotline
1-800-262-2463 (COCAINE)

National Runaway Hotline
1-800-621-4000

Infant and Child Loss
www.infantandchildloss.org
1-800-808-SIDS

Note from the Editor

Montgomery County is highlighted in this issue due to the fact that they have been the model project county that developed the Perinatal Network newsletter and information is most complete for them at this time.

Their role as trailblazers for this communications publication is to be congratulated!

We hope to have resources and more articles from all areas of Maryland as the newsletter becomes known and contributors statewide begin to submit resources and articles.

Teen Pregnancy Resources

Adolescent Family Life Program, Office of Population Affairs
301-594-4004

Alan Guttmacher Institute
202-296-4012

Advocates for Youth
202-347-2263

Family Resources Coalition
312-341-0900

March of Dimes, White Plains, NY
1-800-367-6630

March of Dimes, Maryland
410-752-7990

National Campaign to Prevent Teen Pregnancy
202-857-8655
www.teenpregnancy.org

National Organization on Adolescent Pregnancy, Parenting and Prevention
301-913-0378

Planned Parenthood Federation of America
212-541-7800

Southern Center on Adolescent Pregnancy Prevention
202-624-5897

Web Sites

Child Trends, Inc.
www.childtrends.org

Campaign for Our Children
www.cfoc.org

Children, Youth and Family Consortium

www.cfyc.umn.edu

Contraceptive Choices: The Ultimate Guide to Birth Control
www.thriveonline.oxygen.com/sex/contraceptive_choices/index.html

National Center for Education in Maternal and Child Health,
www.ncemch.org/RefDeskpadolpreg.html